

APPLICATION FOR CANDIDATES REQUESTING
SPECIAL TESTING ACCOMMODATIONS IN
ACCORDANCE WITH THE AMERICANS WITH
DISABILITIES ACT



Prepared by
Practitioner Reporting & Examination Services Unit
Bureau of Operations
Division of Medical Quality Assurance

Completion of this form meets the requirements under 64B-1.005, Florida Administrative Code (F.A.C) for requesting special testing accommodations in accordance with the Americans with Disabilities Act (ADA).

Copyright © 2011 Florida DOH
DH-MQA 4000, 2/2011

**PART I OF THE APPLICATION FOR CANDIDATES REQUESTING
SPECIAL TESTING ACCOMMODATIONS IN ACCORDANCE WITH THE
AMERICANS WITH DISABILITIES ACT**

APPLICATION INSTRUCTIONS:

- A. Who Should File the Application:** Candidates seeking special testing accommodation for an ADA disability should complete this application. If applying for any other accommodation such as a religious conflict, request an application for special testing accommodations for candidates seeking accommodation due to a religious conflict.
- B. Application Submission Deadline:** **Completed** applications should be submitted at least **sixty (60) days** prior to the examination for which you are requesting special testing accommodations.
- C. Documentation Needed:** Applications must be supported by documentation certifying the disability. Documentation must be from a qualified professional appropriate for evaluating the disability, **pursuant to Chapters 490 (Psychological Services), 458 (Medical Practice), 459 (Osteopathy), 461 (Podiatry), 463 (Optometry), or 468, Part I (Speech Language Pathology & Audiology), Florida Statutes**, or by a practitioner in one of the above listed fields who is licensed in a comparable jurisdiction.
- D. Review:** Review of a request for special-testing accommodations will be deferred until the necessary documentation is submitted.
- E. Please type or print all information on the application.** Do not leave sections blank. Put NA if the section does not apply.
- F. Confidentiality.** To protect confidentiality, always send special testing accommodation information **separately to the address below. Do not include these materials with an examination application.** All materials received related to special testing accommodations will be held in confidence.

- G. Returning the Application: Do not send your request with your licensure application because this will delay action on your application.** Mail your completed application for requesting special testing accommodations and documentation to:

Department of Health
Bureau of Operations, Practitioner Reporting &
Examination Services
ATTENTION: Special Testing Coordinator
4052 Bald Cypress Way, Bin # C-90
Tallahassee, FL 32399-3260

Phone: (850) 245 -4252

Fax: (850) 487-9537

Do not mail your application for licensure or examination to this address.

DO NOT SEND THIS APPLICATION TO THE BOARD OFFICE.

SECTION 4: ACCOMMODATION(S) REQUESTED:

Separately list each accommodation requested. Name your disability(ies) that require(s) this accommodation.

SECTION 5: PERSONAL STATEMENT:

In order to document your need for accommodation, please attach a personal statement describing your disability and its impact on your daily life and educational functioning.

SECTION 6: LENGTH OF TIME WITH THE DISABILITY AND PRIOR ACCOMMODATION:

a. How long ago was your disability first professionally diagnosed?

- less than 1 year 1-2 years 2-4 years 5 or more years

b. Check any prior classroom or test accommodation(s) that you have received:

(1) Secondary or elementary school Yes No

If yes, accommodation(s) received: _____
(If extra time, note amount given): _____

(2) College (if applicable) Yes No

If yes, accommodation(s) received: _____
(If extra time, note amount given): _____

(3) Other Year _____

Accommodation(s) received: _____
(If extra time, note amount given): _____

SECTION 7: Certification/Authorization:

I certify that the above information is true and accurate. If test accommodations granted to me include a deviation from the standard testing time schedule, I agree that, from the time I begin the examination until I have completed it, I will not communicate in any way, to the extent possible, with any other individuals taking the examination and I will not communicate in any way with any such individuals about the content of the examination.

Signature: _____ Date: _____

I understand the Department of Health will use the information obtained by this authorization to determine eligibility for a reasonable accommodation in regard to this examination by reason of my disability. This information will remain confidential pursuant to provisions in Section 455.647, Florida Statutes. If clarification or further information regarding the documentation provided is needed, I authorize the Department of Health authority to contact the professional(s) who diagnosed the disability and/or those entities to communicate with the Department of Health in this regard to provide the Department with such clarification and/or further information.

Signature: _____ Date: _____

**PART II OF THE APPLICATION FOR CANDIDATES REQUESTING
SPECIAL TESTING ACCOMMODATIONS IN ACCORDANCE
WITH THE AMERICANS WITH DISABILITIES ACT**

PART II - INSTRUCTIONS FOR THE PRACTITIONER COMPLETING THIS PART

A. Who Should Complete Part II

Applications for special testing accommodations must be supported by documentation certifying the disability. Documentation must be from a qualified professional appropriate for evaluating the disability, **pursuant to Chapters 490 (Psychological Services), 458 (Medical Practice), 459 (Osteopathy), 461 (Podiatry), 463 (Optometry), or 468, Part I (Speech Language Pathology & Audiology), Florida Statutes.** Documentation of the disability by a practitioner in the same field from another state may be made if the practitioner is licensed in that state and practicing the profession at the time the diagnosis was made. If you are not licensed in Florida by one of the Boards listed above or as described in another state, **do not complete this form.**

If you are not a Psychologist, Medical Physician, Osteopathic Physician, Podiatrist, Optometrist, or licensed to practice Speech and Language Pathology and Audiology, **do not complete this form.**

Professionals conducting assessments and rendering diagnoses of learning disabilities must be qualified to do so. Comprehensive training in the differential diagnosis of various learning disabilities is required. The evaluator should provide professional credentials, including information about licensure or certification, the area of specialization and employment. Please designate the state where practicing.

B. Application Submission Deadline: This complete Part II form should be submitted along with Part I of the application at least **sixty (60)** days prior to the examination for which special testing accommodations are requested

C. Please type or print all information on the application. Do not leave sections blank. Put NA if the section does not apply.

D. Confidentiality. All materials received will be held in confidence.

E. Attach Documentation: Attach any additional documentation to the application. You must provide the method and tests used to document the disability. Do not leave that question blank or answer NA.

F. Special Testing Accommodations Requested: You must list the accommodations that your patient will require to accommodate the disability in the testing setting and describe why the accommodation is needed.

Please Return Part II to:

Department of Health
Bureau of Operations, Practitioner Reporting &
Examination Services
ATTENTION: Special Testing Coordinator
4052 Bald Cypress Way, Bin # C-90
Tallahassee, FL 32399-3260

Phone: (850) 245 -4252

Fax: (850) 487-9537

**PART II OF THE APPLICATION FOR CANDIDATES REQUESTING
SPECIAL TESTING ACCOMMODATIONS IN ACCORDANCE
WITH THE AMERICANS WITH DISABILITIES ACT**

(Please type or write legibly)

SECTION I - PRACTITIONER DATA (The practitioner must complete this section.)

PRACTITIONER NAME: _____

LAST

FIRST

MI

OFFICE ADDRESS (INCLUDE CITY & STATE): _____

TELEPHONE: (_____) _____ YOUR PROFESSION: _____

FLORIDA LICENSE NO: _____ OTHER LICENSE NO.(INCLUDE STATE): _____

CERTIFICATION: _____ SPECIALTY: _____

SECTION 2 - PATIENT DATA (The Practitioner must complete this section.)

NAME OF THE PATIENT: _____ PATIENT'S PROFESSION: _____

DATE PATIENT FIRST CONSULTED: _____ DATE PATIENT LAST SEEN: _____
Mo/day/year Mo/day/year

DIAGNOSIS OF DISABILITY: _____

NAME OF TEST(S) OR PROCEDURES USED TO DIAGNOSE THE DISABILITY (This section must be completed):

LENGTH OF TIME WITH CONDITION: _____

RECOMMENDED ACCOMMODATION FOR TESTING (This section must be completed): _____

REASON THAT THE RECOMMENDED ACCOMMODATIONS ARE NEEDED: _____

SECTION 3: CERTIFICATION

I hereby certify that the above information is true and is given pursuant to the authorization to release information by my patient. I declare that the foregoing statements and those in any required accompanying documents or statements are true. I understand that pursuant to Chapter 456.067, Florida Statutes, the act of giving false information may be cause for loss of a license or denial of possible licensure. I hereby certify that I personally completed this portion of this application and that I may be asked to verify the above information at any time.

Signature _____ Date _____